ST. LUKE'S REGIONAL MEDICAL CENTER
Sioux City, Iowa

MR Number: 17330138 Acct. Number: 00147322952
Pt. Name: KUNKEL, TROY D Pt. Location: X519
Dictated by: LISA A REMER, MD

cc: LISA A REMER, MD

Admission Date: 04/25/2008
Discharge Date: 04/26/2008

IDENTIFICATION INFORMATION AND REASON FOR ADMISSION:
This is a 25-year-old male who has a history of insulin-dependent diabetes mellitus. He was admitted for fever with stiff neck and rule out meningitis.

CONSULTANTS:
1. Bertha Ayi, M.D.
2. Daniel Lampley, M.D.

LABORATORY DATA:
Blood sugars have been fairly well controlled, running a bit low 185 and 75. CBC showed normal white count of 9.3 and hemoglobin 16.8. Sodium 136, potassium 3.7 and creatinine 0.5. Insulin screen was negative. Blood cultures are negative at this point. UA showed no evidence of infection, but some fluid crystals.

HOSPITAL COURSE:
The patient was admitted and infectious disease was consulted. Blood sugars were obtained q.i.d., labs as above. He was given IV fluids. Yale protocol was initially started though the patient _____ that at that point. DuoNeb treatments were given. Meningitis was affectively ruled out as far as resolution of the patient's symptoms and chest x-ray was obtained to further monitor for pneumonia though the chest x-ray was negative, it was thought that his symptoms _____ represents pneumonia in fact.

ASSESSMENT:
1. Pneumonia.
2. Insulin-dependent diabetes mellitus.
3. Tobacco use disorder.
4. History of diabetic ketoacidosis in the past.
5. Mild hypoglycemia.

PLAN:
The patient will be dismissed. Had discussed with him that we would prefer to keep him a day or so longer, however, he has a child who is 9-days old and now he will be phoned to Children's Hospital in Omaha for meningitis. He would like to be there and certainly it is appropriate for him to do so. He has been dismissed on Levaquin 750 mg daily x7 days, cephalexin 500 mg 1 p.o. t.i.d. x7 days. He will follow up with Dr. Peterson in the next 1-2 weeks or sooner p.r.n. problems.

DISCHARGE MEDICATIONS:
To be those as mentioned. He will take his Lantus insulin and Novolog insulin as before with 65 units of Lantus daily and 10

units of Novolog with each meal. I recommended that he quit smoking. He is also given a prescription for lorazepam 0.5 mg q. 8h. p.r.n. for anxiety as needed.

eScription document:9-7457858 Confirmation:265010 1F

LR/fi
D: 04/26/2008 2:46 P
T: 04/27/2008 4:24 A
Doc#: 2133228

DISCHARGE SUMMARY
Authenticated by LISA A REMER, MD On 1/20/09 8:59:25 PM

ST LUKES SIOUX CITY
ENCOUNTER TRANSCRIPTION

PATIENT: KUNKEL, Troy PROVIDER: PIPE ON HEAD, GENEVIEVE
ADDRESS: 2005 MCKINLEY ST DATE: 26Apr2008 LOC: INPATIENT
SIOUX CITY, IA 51109 ACCOUNT#: 147322952
PRIMARY DX: CPT: PROC:
SECONDARY DX: MRN: 17330138 ROOM: PAGE: 1

ST LUKE'S REGIONAL MEDICAL CENTER

Actual Discharge Date: April 26th, 2008

HOME INSTRUCTIONS FOR: Troy Kunkel

Please bring this sheet to your next doctor office visit and to your pharmacy when filling your prescription.

MEDICATIONS

- Levaquin 750mg - Take 1 tablet by mouth x 7 days

- Keflex 500mg - Take 1 tablet by mouth three times daily x 7 days

- ATIVAN 0.5MG - TAKE BY MOUTH EVERY SIX HOURS AS NEEDED.

DIET/FLUIDS

- Diabetic Diet

APPOINTMENTS

- YOU WILL NEED TO CALL AND SCHEDULE A FOLLOW UP APPOINTMENT TO SEE DR PETERSON IN THE OFFICE LOCATED AT 2600 OUTER DRIVE NORTH SIOUX CITY IA 712-239-3300. YOU WILL NEED TO BE SEEN IN 1-2 WEEKS

ACTIVITY

- As tolerates

For any further problems or concerns contact your doctor or call My Nurse at 1-877-242-8899. Contact your doctor if your pain is not under control.

I have read and understand the above instructions:

_____
Signature of patient/significant other/parent/guardian

E N C O U N T E R R E P O R T

DISCHARGE INSTRUCTIONS REPORT

Report - Date/Time: 26Apr08 12:30pm

: 17330138
Patient: KUNKEL, Troy D.

SIOUX CITY IA 51109 147322952

Report Name: Inpatient Discharge Instructions Type: TRX

ST LUKE'S REGIONAL MEDICAL CENTER

Actual Discharge Date: April 26th, 2008

HOME INSTRUCTIONS FOR: Troy Kunkel

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CTIVITY

- As tolerates

For any further problems or concerns contact your doctor or call My Nurse at 1-877-242-8899. Contact your doctor if your pain is not under control.

4/26

SLT0140

DISCHARGE INSTRUCTIONS REPORT

Report - Date/Time: 26Apr08 12:30pm

[illegible]: 17330138
[illegible]ient: KUNKEL, Troy D.

SIOUX CITY IA 51109 147322952

Report Name: Inpatient Discharge Instructions Type: TRX

I have read and understand the above instructions:

X _____

Signature of patient/significant other/parent/guardian

History & Physical Report #1

KUNKEL, Troy D.
ATTEND PETERSON, PAUL
ADM 25Apr2008 DOB [redacted]1983 25
ACCT 147322952 MR 17330138

Troy D. Kunkel
1/25/2008 3:49 PM
Location: INDIAN HILLS CLINIC
Patient ID: 410990
DOB [redacted]1983
Single / Language: Undefined / Ethnicity: Undefined
Male

History of Present Illness (Carol L Miller, RN; 4/25/2008 3:58 PM)

The patient is a 25 year old male who presents with a complaint of headache . headache notes: Pt comes in with c/o headache and states his new daughter has Meningitis. Pt states he has a fever of 103.1 last night and fever has been up, nausea and vomiting on aff for the last 3 days. and down for the last 3 days, states he had a severe headache,body aches, neck pain with severe sharp stabbing pain on left side of neck and jaw. Pt c/o severe night sweats and BGMs bouncing upand down rapidly. Pt also c/o severe thirst.

Allergies (Paul D Peterson, DO; 4/25/2008 4:32 PM)

No Known Drug Allergies

Past Medical History (Paul D Peterson, DO; 4/25/2008 4:32 PM)

Hospitalizations - Dates/Reasons. 04/03/2008 SLRMC-Diabetic ketoacidosis, severe dehydration, bronchitis, recent thyroid ablation for Graves disease with hyperthyroidism, chronic tobacco abuse disorder, substance abuse with marijuana--DISCH 4/4/08.
Hospitalizations - Dates/Reasons. 03/18/2008 SLRMC-Gastroenteritis; dehydration, hyperglycemia; known diabetes, hyperthyroidism-DISCH 3/19/08.
St. Luke's Admit. 12/04/2007 See D/C report 12-6-2007; 1. Diabetic ketoacidosis. 2. Thyrotoxicosis. 3. New onset diabetes mellitus type II 4. hyponatremia. 5. Dehydration 6. Abdominal 7. Electrolyte imbalance.
Fractured left Tib/Fib and was followed by Dr. Stokesbury.. 2007 This did not require surgery.
Hospital Admit. 07/2006 MVA; fractured right clavicle and concerned about concussion so was there overnight.
Splenectomy. At age 8; patient had removed for spherocytosis and also a bit of the pancreas. per Dr. Morris. This was for Spherocytosis.
HEREDITARY SPHEROCYTOSIS (282.0)
DIABETES MELLITUS TYPE II (250.00)
HYPOSMOLALITY AND/OR HYPONATREMIA (276.1)
VOLUME DEPLETION DISORDER; DEHYDRATION (276.51)
ABDOMINAL PAIN (789.00)
DIABETES MELLITUS WITH KETOACIDOSIS; TYPE II OR UNSPECIFIED TYPE, UNCONTROLLED (250.12)
HYPERTHYROIDISM w/ h/o Thyrotoxicosis. s/p Ablation on 3/31/08 SLRMC

Family History (Paul D Peterson, DO; 4/25/2008 4:32 PM)

Hereditary Spherocytosis. Paternal history
Diabetes Mellitus. Brother, Paternal Uncle, Paternal Aunt, Maternal Family Members

Social History (Paul D Peterson, DO; 4/25/2008 4:32 PM)

Marital Status. Single
Career/Job. Glass Palace
Non Drinker/No Alcohol Use
Pt wears contacts/glasses
Siblings. Pt has 1 brother and 2 sisters.
Tobacco Use. Smokes 1 pack of cigarettes per day x 11 years, Recently quit tobacco use 3/2008

Medication History (Carol L Miller, RN; 4/25/2008 3:50 PM)

Xanax (0.5MG Tablet 1 Oral every 6 hrs prn, Taken starting 04/04/2008) Ordered - Hx Entry.
Propylthiouracil (50MG Tablet 3 (three) Oral four times daily, Taken 04/02/2008 to 04/25/2008) Inactive - Hx Entry. (pt called with results of thyroid scan and instructed needs to take above dose for 2 weeks and to call for refill to determine any changes. Pt also instructed to have labs drawn in 6 wks. Called into Walg/DT...)
predniSONE (20MG Tablet 2 Oral daily, Taken 04/01/2008 to 04/25/2008) Inactive - Hx Entry.
Lantus (100UNIT/ML Solution 65 units Subcutaneous daily) Active - Hx Entry.
NovoLog (100UNIT/ML Solution 10 units Subcutaneous before every meal) Active - Hx Entry.

Review of Systems (Paul D Peterson, DO; 4/25/2008 4:33 PM)

General: *Present*- **Fatigue** and **Fever**. *Not Present*- Night Sweats.
Skin: *Not Present*- Hair Loss, Itching, New Lesions and Rash.
HEENT: *Not Present*- bothered by bright light (photophobia), eye discharge, Visual Disturbances, Decreased Hearing, Ear Pain, Nose Bleed, Frequent Colds, Nasal Congestion, Bleeding Gums, Voice Changes and Hoarseness.
Neck: *Not Present*- Neck Pain and Swollen Glands.
Respiratory: *Not Present*- Cough, Snoring, Difficulty Breathing, coughing up blood, Sputum Production and Wheezing.
Cardiovascular: *Not Present*- Difficulty Breathing On Exertion, Difficulty Breathing Lying Down, Elevated Blood Pressure, Irregular Heart Beat, Palpitations, Rapid Heart Rate and Swelling of Extremities.
Gastrointestinal: *Not Present*- Abdominal Pain, Change in Bowel Habits, Constipation, Diarrhea, Difficulty Swallowing, Gas, Heartburn, Indigestion, Nausea, Rectal Bleeding and Vomiting.
Male Genitourinary: *Present*- **Frequency**, **Nocturia** and **Polyuria**. *Not Present*- Blood in Urine, Change in Urinary Stream, Discharge, Hesitancy, Impotence, Incontinence, Painful Urination, genital sores, Testicular Mass, Urethral Discharge, Urgency and Urinating at Night.
Musculoskeletal: *Present*- Muscle Weakness. *Not Present*- Joint Stiffness, Joint Swelling and Muscle Pain.
Neurological: *Not Present*- Seizures, Tremor and Weakness.
Endocrine: *Present*- **Excessive Thirst** and **Thyroid Problems** (*recent Thyroid Ablation*). *Not Present*- Cold Intolerance, Excessive Urination, Heat Intolerance and Sexual Dysfunction.
Hematology: *Not Present*- Abnormal Bleeding, Anemia, Easy Bruising and Enlarged Lymph Nodes.

SLT0142

1005B-006

Vitals (Carol L Miller, RN; 4/25/2008 3:49 PM)
4/25/2008 3:49 PM
Temp.: 98.3° F (Oral) **Pulse:** 84 (Regular)
BP: 106/80 Manual (Sitting, Left Arm, Standard)

KUNKEL, Troy D.
ATTEND PETERSON, PAUL
ADM 25Apr2008 DOB [redacted]1983
ACCT 147322952 MR 17330138

Physical Exam (Paul D Peterson, DO; 4/25/2008 4:09 PM)
The physical exam findings are as follows:

General
Mental Status - Alert. **General Appearance** - Cooperative and Sickly. Not in acute distress. **Build & Nutrition** - Well nourished and Well developed. **Hydration** - Well hydrated.

Integumentary
General Characteristics: Skin Moisture - skin is clammy and skin is excessively moist. **Temperature** - increased warmth is noted.

Head and Neck
Head - normocephalic, atraumatic with no lesions or palpable masses.
Neck
Global Assessment - supple. no palpable mass on the right and no palpable mass on the left.
Trachea - midline.

ENMT
Ears
External Auditory Canal - Left - no cerumen impaction noted. **Right** - no cerumen impaction noted.
Otoscopic Exam: Tympanic Membrane - Left - tympanic membrane is gray in appearance. no bulging noted, no inflammation observed and no retraction of TM observed. **Right** - tympanic membrane is gray in appearance. no bulging noted, no inflammation observed and no retraction of TM observed.
Nose and Sinuses
Inspection of the nares - **Left** - Patent. **Right** - Patent. **Nasal Mucosa - Bilateral** - no congestion observed.
Mouth and Throat
Oral Cavity/Oropharynx: Teeth - Normal. **Oral Mucosa** - lesion(s) not present and no dryness noted. **Oropharynx** - Normal.

Chest and Lung Exam
Inspection:
Chest Wall: - Normal.
Shape - Normal and Symmetric. **Movements** - Symmetrical. **Accessory muscles** - No use of accessory muscles in breathing.
Palpation: Palpation of the chest reveals - Non-tender.
Auscultation:
Breath sounds: Bronchial - Both Lung Fields.
Adventitious Sounds - Inspiratory wheeze - Right Lung Field.

Cardiovascular
Palpation/Percussion: Examination by palpation and percussion reveals - No Thrills.
Point of Maximal Impulse: - Normal.
Auscultation: Heart Sounds - S1 WNL and S2 WNL. No S3.
Murmurs & Other Heart Sounds: Auscultation of the heart reveals - No Murmurs.

Assessment & Plan (Paul D Peterson, DO; 4/25/2008 4:35 PM)
FEVER (780.6)
Bacterial Meningitis Exposure
Plans:
CBC, PLATELETS & AUT DIFF (85025) - Routine
Patient admitted to hospital-see admit orders.

DIABETES MELLITUS TYPE II (250.00)
Plans:
GLUCOSE (82947) - room 20 - Routine
COUGH (786.2)
HEREDITARY SPHEROCYTOSIS (282.0)
prior Spleenectomy
DIABETES MELLITUS WITH KETOACIDOSIS; TYPE II OR UNSPECIFIED TYPE, UNCONTROLLED (250.12)
DEHYDRATION (276.50)
HYPERTHYROIDISM w/ h/o Thyrotoxicosis
s/p Ablation on 3/31/08 SLRMC

Paul D Peterson, DO

ST. LUKE'S REGIONAL MEDICAL CENTER
Sioux City, Iowa

MR Number: 17330138 Acct. Number: 00147322952
Pt. Name: KUNKEL, TROY D Admit Date: 04/25/2008
Pt. Location: X5A2 X519 Service Date: 04/26/2008
Doc# 2132685
Dictated by: BERTHA S AYI, MD

cc: BERTHA S AYI, MD

The patient is a pleasant 25-year-old gentleman who was admitted to the hospital with a history of fevers of 103, bodyaches, neck pain with sharp stabbing pain on the left side of his neck with severe night sweats and irregular blood glucose levels.

His past medical problems include insulin-dependent diabetes, recent history of Graves disease with radioablation of a goiter. He was admitted for further evaluation. One of his set of twin daughters has proven bacterial meningitis.

On follow-up today, his influenza screen was negative.

He still has quite a bad headache. He is sounding very nasal in his speech. He does not look that well. His pupils are reactive. He has no oral lesions. However, his lung exam shows pretty coarse rhonchi and wheezes bilaterally. He also coughed on several times while I was examining him. His temperature today is 96.5, pulse of 104, respiratory rate 20, blood pressure 140/77. His urine output has been good. Extremities do not reveal any edema. Skin is otherwise clear on psychiatric exam. Affect is a little blunt.

DATA REVIEW:
Shows negative influenza screen.

The patient also reports he has had a chest x-ray done which may not have been reported on.

His other data show a free thyroxine level of 3.3, white cell count 9.3 and a normal urinalysis.

ASSESSMENT AND PLAN:
A 25-year-old gentleman with a lot of medical problems for someone his age.

1. I think he has a respiratory infection going on. This is based on the following criteria - he has been coughing. He does not feel well. He had a fever and today his lung exam showed frank bilateral wheezing and rhonchi. His air entry is very poor. I would recommend the following - I would recommend DuoNeb treatments every 4 hours by respiratory therapy. He reports he does not have a history of asthma. I would also put him on IV Rocephin 2 grams every 24 hours. I am also going to repeat a chest x-ray because his first chest x-ray was a portable which may have been subject to the fact that he was dehydrated. Now that he has been hydrated some more, I think it is necessary.

2. Ongoing headaches likely related to his upper and lower respiratory tract infection. His influenza screen was negative. I will obtain a sputum culture as well.
3. Possibility of meningitis. He continues to have a headache but judging by the ongoing respiratory signs and symptoms, I think this is likely to be pneumonia more than meningitis. If his headache persists, we may do a lumbar puncture.
4. Diabetes mellitus type II.
5. Hyperthyroidism with history of thyrotoxicosis status post ablation on 3/31/08. Now he is hypothyroid judging by his TSH.

I think we should keep him here today. Still does not look good.

Thank you so much for allowing me to be involved in his care. It is a pleasure to do so and I will continue to follow him with you.

eScription document:9-7457715 Confirmation:264838 MMB

BSA/mmb
D: 04/26/2008 7:42 A
T: 04/26/2008 10:35 A
Doc#: 2132685

PROGRESS NOTE
Authenticated by BERTHA S AYI, MD On 10/09/08 3:18:51 PM

ST. LUKE'S REGIONAL MEDICAL CENTER
IOWA HEALTH SYSTEM

DATE 4/25/08 TIME 1630 **EACH ENTRY MUST BE SIGNED** IMPRINTER

KUNKEL, Troy D.
ATTEND PETERSON, PAUL
ADM 25Apr2008 DOB [redacted]1983
ACCT 147322952 MR 17330138
Troy Kounkel

Admit to:

☒ **Inpatient Care:** (requiring inpatient services and stays longer than 24 hours)
Area: 5 MED - ISOLATION

☐ **Observation:** (determine need for inpatient care, repeat exams, short term treatment or clarify the course of an illness)
Area:

☐ **Extended Ambulatory:** (requiring longer than traditional ambulatory service recovery period or late or weekend surgical cases)
Area:

Physician's Signature

Respiratory + Contact Isolation
Routine Vitals

DATE TIME **EACH ENTRY MUST BE SIGNED** IMPRINTER

Diabetic 1800 cal Diet
Yale Insulin Protocol
Infectious Disease Consult - notify
CBC, Lactic Acid, CRP, SED Rate
Blood Culture x2
Serum Ketones, MGA, TSH, Total T4, Free T4
IV: NS at 200 cc/hr
Ativan 1mg p.o. q 4-6' prn anxiety
Nicoderm patch 21 mg/hr apply q24°
Page Dr. Langley with Room # when pt. arrives
Tylenol 500, i-ii po q 4-6' prn
Portable CXR upon arrival

DATE TIME **EACH ENTRY MUST BE SIGNED** IMPRINTER

Activity: up ad lib. - Isolation
Holli Sullivan RN 4/25/08 1800

SCANNED
INITIAL: [signature]
DATE / TIME: 4/25/08 1740

SLT0162

1005B-010

X519-P KUNKEL, Troy D MR#: 17330138 ACCT: 14/322952 I
AGE: 25Y DOB: [redacted]1983 GENDER: M
Admitting: PETERSON, PAUL D CC: possible meningitis
Attending: Unknown REASON FOR ADM: possible meningitis

ALLERGY/INTOLERANCES

Medication Allergies Reaction
MEDS-NKA

Intolerances
Food Intolerances
No Known Food Allergies
Contrast Media Intolerances
No Known Contrast Media Intolerance
Other Intolerances
latex

CATEGORY/FINDING	RESULT	CAREGIVER	TITLE	
FORM: ADULT INITIAL HX	Date: 25Apr2008	Time: 17:30		
GENERAL ADMISSION DATA-AD				
ADMISSION DATA-AD				
Orient to room/unit	Patient	Fulton, Pamela K	RN	25Apr2008 17:33
Pt Bill of Rights/Responsibilities given	Patient	Fulton, Pamela K	RN	25Apr2008 17:33
Pain brochure given	Patient	Fulton, Pamela K	RN	25Apr2008 17:33
Reason for admission	weakness	Fulton, Pamela K	RN	25Apr2008 19:11
Admitted from	Dr office	Fulton, Pamela K	RN	25Apr2008 17:33
Mode of arrival	Wheelchair	Fulton, Pamela K	RN	25Apr2008 17:33
Info obtained from	Patient	Fulton, Pamela K	RN	25Apr2008 17:33
ADVANCE DIRECTIVES				
Advance directive info provided by	Patient	Fulton, Pamela K	RN	25Apr2008 17:33
Patient states	"Whatever it takes to revive Me"			
VALUABLES/DISPOSITION				
Glasses/Contacts	With fam	Fulton, Pamela K	RN	25Apr2008 17:33
IMMUNIZATION/VACCINE HX				
IMMUNIZATIONS HX				
Date of last Pneumococcal vaccine (yr)	2007	Fulton, Pamela K	RN	25Apr2008 17:34
Reason not to give Pneumococcal vaccine	Current	Fulton, Pamela K	RN	25Apr2008 17:34
Pneumococcal vaccine decision	Current	Fulton, Pamela K	RN	25Apr2008 17:34
Date of last Influenza vaccine (mo/yr)	2007	Fulton, Pamela K	RN	25Apr2008 17:34
Reason not to give Influenza vaccine	Current	Fulton, Pamela K	RN	25Apr2008 17:34
Influenza vaccine decision	Current	Fulton, Pamela K	RN	25Apr2008 17:34
HM/VASC ACCESS/SURG/TRANS HX				
HOME MEDS-AD				
Home medications	Yes	Fulton, Pamela K	RN	25Apr2008 17:37

CURRENT MEDICATIONS LIST

This is to be a list of all meds the patient has been taking: Prescription,Over the Counter,Vitamins,Herbs,etc

MEDICATION (include dose, frequency and last dose)

_Xanax 0.5mg every 6 hrs. 4/25/08

SLT0166

X519-P KUNKEL, Troy D MR#: 17300138 ACCT: 14732295Z I
AGE: 25Y DOB: [redacted]1983 GENDER: M
Admitting: PETERSON, PAUL D CC: possible meningitis
Attending: Unknown REASON FOR ADM: possible meningitis

CATEGORY/FINDING	RESULT	CAREGIVER	TITLE	
HOME MEDS-AD				
	_Novolog Regular 10 units before meals. 4/25/08 _Propranolol 20mg twice daily. 4/25/08 _Lantus insulin 65 units in morning. 4/25/08 _			
Hm med info prov by	Patient	Fulton, Pamela K	RN	25Apr2008 17:37
Home pharmacy	greenville	Fulton, Pamela K	RN	25Apr2008 17:37
Home meds disposition	Not w/pt	Fulton, Pamela K	RN	25Apr2008 17:37
SURGICAL/PROCEDURAL HX				
Surgical / Procedural history	Yes	Fulton, Pamela K	RN	25Apr2008 17:37
	PAST SURGERIES/PROCEDURES Surgery/Procedure Date spleenectomy 9yrs old			
TRANSFUSION HX				
Previous transfusions	No	Fulton, Pamela K	RN	25Apr2008 17:37
MED HX-RESPIRATORY/CV/GI				
RESP HX				
Asthma	Y	Fulton, Pamela K	RN	25Apr2008 17:37
Respiratory Hx-other	see note	Fulton, Pamela K	RN	25Apr2008 17:37
	pt states he does have trouble breathing but denies use of inhalers etc. States mainly short of breath in AM & coughs up large amounts of sputum.			
CARDIOVASC HX				
Hypertension	Y	Fulton, Pamela K	RN	25Apr2008 17:37
Arrhythmias (list)	Y	Fulton, Pamela K	RN	25Apr2008 17:37
	pt states can detect his heart fluctuating in speed. States he has to sit down sometimes as his heart is beating so fast.			
GASTROINTESTIONAL HX				
Ulcers	Y	Fulton, Pamela K	RN	25Apr2008 17:37
Gastrointestinal Hx other	see note	Fulton, Pamela K	RN	25Apr2008 17:37
	pt states it has been a long time since he has passed a regular formed stool. Currently he is passing runny or soft stool.			
MED HX-GU/REPR/NEURO/MS/ENT				
NEUROLOGICAL HX				
Headaches	Migraine	Fulton, Pamela K	RN	25Apr2008 17:37
EENT HX				
Loose teeth	Y	Fulton, Pamela K	RN	25Apr2008 17:37
EENT Hx-other	see note	Fulton, Pamela K	RN	25Apr2008 17:37
	poor dental care			
MED HX-PSYCHOSOCIAL/MISC				
MISCELLANEOUS MEDICAL HX				

SLT0167

1005B-012

X519-P KUNKEL, Troy D MR#: 1/330138 ACCT: 147322952 I
AGE: 25Y DOB: [redacted]1983 GENDER: M
Admitting: PETERSON, PAUL D CC: possible meningitis
Attending: Unknown REASON FOR ADM: possible meningitis

CATEGORY/FINDING	RESULT	CAREGIVER	TITLE	
MISCELLANEOUS MEDICAL HX				
Diabetes	insulin	Fulton, Pamela K	RN	25Apr2008 17:37
Thyroid disorder	Y	Fulton, Pamela K	RN	25Apr2008 17:37
graves disease				
MEDICAL HISTORY.				
Personal Physician	Peterson	Fulton, Pamela K	RN	25Apr2008 17:37
SUBSTANCE USAGE				
TOBACCO USAGE				
Tobacco use/exposure history	W/I 12 mo	Fulton, Pamela K	RN	25Apr2008 17:38
states quit last Sunday 12-2-7				
Tobacco type used	cigarettes	Fulton, Pamela K	RN	25Apr2008 17:38
Tobacco amount/day	1pk /day	Fulton, Pamela K	RN	25Apr2008 17:38
# years tobacco used	13	Fulton, Pamela K	RN	25Apr2008 17:38
Verbal advice to quit tobacco given	Yes	Fulton, Pamela K	RN	25Apr2008 17:38
Quit tobacco info given	Stay quit	Fulton, Pamela K	RN	25Apr2008 17:38
Doesn't want more info to quit tobacco	Y	Fulton, Pamela K	RN	25Apr2008 17:38
Would like more info to quit tobacco	Y	Fulton, Pamela K	RN	25Apr2008 17:38
CAFFEINE USAGE				
Caffeine intake/day	Min amt	Fulton, Pamela K	RN	25Apr2008 17:38
ALCOHOL/OTHER SUBSTANCES				
Alcohol type	none	Fulton, Pamela K	RN	25Apr2008 17:38
quit 6-7 years				
Street drug use	Y	Fulton, Pamela K	RN	25Apr2008 17:38
Not since a teenager.				
LEARNING NEEDS ASMT				
PT-CAREGIVER LEARNING NEEDS				
Receptive to learning	Yes	Fulton, Pamela K	RN	25Apr2008 17:38
Patient preferred learning style	Reading	Fulton, Pamela K	RN	25Apr2008 17:38
Patient-How happy are you w/your reading	Read well	Fulton, Pamela K	RN	25Apr2008 17:38
LEARNING BARRIERS				
No learning barriers identified	Y	Fulton, Pamela K	RN	25Apr2008 17:38
SOCIAL FACTORS/DC PLANNING				
ABUSE SCREENING				
Been hurt or made to feel afraid	No	Fulton, Pamela K	RN	25Apr2008 17:38
Feel exploited/taken advantage of	No	Fulton, Pamela K	RN	25Apr2008 17:38
Feel neglected	No	Fulton, Pamela K	RN	25Apr2008 17:38
Feel threatened	No	Fulton, Pamela K	RN	25Apr2008 17:38
CULTURAL-SPIRITUAL				
Spiritual concerns	None	Fulton, Pamela K	RN	25Apr2008 17:38
Cultural tradition needs during stay	None	Fulton, Pamela K	RN	25Apr2008 17:38
DISCHARGE PLANNING				
Residence before hospitalization	Hm wo help	Fulton, Pamela K	RN	25Apr2008 17:38
Discharge plan A	Home w/fam	Fulton, Pamela K	RN	25Apr2008 17:38
CONTACT INFORMATION				

X519-P KUNKEL, Troy D MR#: 17330138 ACCT: 147322952 I
AGE: 25Y DOB: [redacted]1983 GENDER: M
Admitting: PETERSON, PAUL D CC: possible meningitis
Attending: Unknown REASON FOR ADM: possible meningitis

CATEGORY/FINDING	RESULT	CAREGIVER	TITLE	
CONTACT INFORMATION				
1st Contact Person	megan	Fulton, Pamela K	RN	25Apr2008 17:38
712-277 2400 home	cell 712 574-4623			
HOME MEDICAL EQUIP				
Other medical supplies/equipment	none	Fulton, Pamela K	RN	25Apr2008 17:38
SCREENING CATEGORIES FF				
LATEX SCREEN FF				
No latex allergy	Y	Fulton, Pamela K	RN	25Apr2008 17:38
FORM: SCREENING CATEGORIES -A	Date: 25Apr2008	Time: 20:00		
FALL RISK/SAFETY ASSESSMENT				
FALL RISK/SAFETY				
History of falling	0	Ebert, Jackie M		25Apr2008 21:00
Secondary diagnosis	0	Ebert, Jackie M		25Apr2008 21:00
Ambulatory aid	0	Ebert, Jackie M		25Apr2008 21:00
IV therapy/saline lock	20	Ebert, Jackie M		25Apr2008 21:00
Gait	0	Ebert, Jackie M		25Apr2008 21:00
Mental status	0	Ebert, Jackie M		25Apr2008 21:00
MORSE FALL SCALE SCORE	20	Ebert, Jackie M		25Apr2008 21:00
MEDS INC FALL RISK				
None identified	Y	Ebert, Jackie M		25Apr2008 21:00
RISK/UNIVRSL INTERVN				
Risk for falls	Low risk	Ebert, Jackie M		25Apr2008 21:00
Universal interventions	Y	Ebert, Jackie M		25Apr2008 21:00
Teach inc risk to fall-unfam surrounding	Y	Ebert, Jackie M		25Apr2008 21:00
INDIVIDUALIZED INTV				
Alarm in place	Bed	Ebert, Jackie M		25Apr2008 21:00
Individualized intervention other	call light	Ebert, Jackie M		25Apr2008 21:01
BRADEN ASMNT				
BRADEN SCALE				
Sensory perception	4	Ebert, Jackie M		25Apr2008 21:01
Skin moisture	3	Ebert, Jackie M		25Apr2008 21:01
Activity level	4	Ebert, Jackie M		25Apr2008 21:01
Mobility	4	Ebert, Jackie M		25Apr2008 21:01
Nutrition status	1	Ebert, Jackie M		25Apr2008 21:01
Friction and shear	3	Ebert, Jackie M		25Apr2008 21:01
BRADEN SCALE TOTAL-	19	Ebert, Jackie M		25Apr2008 21:01
PREVENTIVE SKIN CARE				
Diabetes	Insulin	Ebert, Jackie M		25Apr2008 21:01
FORM: SCREENING CATEGORIES -A	Date: 25Apr2008	Time: 17:41		
FALL RISK/SAFETY ASSESSMENT				
FALL RISK/SAFETY				

SLT0170

X519-F KUNKEL, Troy D MR#: 1739138 ACCT: 14732952 I
AGE: 25Y DOB: [redacted]1983 GENDER: M CC: possible meningitis
Admitting: PETERSON, PAUL D REASON FOR ADM: possible meningitis
Attending: Unknown

CATEGORY/FINDING	RESULT	CAREGIVER	TITLE	
FALL RISK/SAFETY				
History of falling	0	Fulton, Pamela K	RN	25Apr2008 17:42
Secondary diagnosis	0	Fulton, Pamela K	RN	25Apr2008 17:42
Ambulatory aid	0	Fulton, Pamela K	RN	25Apr2008 17:42
iv therapy/saline lock	20	Fulton, Pamela K	RN	25Apr2008 17:42
Gait	0	Fulton, Pamela K	RN	25Apr2008 17:42
Mental status	0	Fulton, Pamela K	RN	25Apr2008 17:42
MORSE FALL SCALE SCORE	20	Fulton, Pamela K	RN	25Apr2008 17:42
MEDS INC FALL RISK				
Antihypertensives	Y	Fulton, Pamela K	RN	25Apr2008 17:42
None identified	Y	Fulton, Pamela K	RN	25Apr2008 17:42
RISK/UNIVRSL INTERVN				
Risk for falls	Low risk	Fulton, Pamela K	RN	25Apr2008 17:42
Universal interventions	Y	Fulton, Pamela K	RN	25Apr2008 17:42
Teach inc risk to fall-unitam surrounding	Y	Fulton, Pamela K	RN	25Apr2008 17:42
INDIVIDUALIZED INTV				
Alarm in place	Bed	Fulton, Pamela K	RN	25Apr2008 17:42
Individualized intervention other	See note Patient is encouraged to use the call light for assistance.	Fulton, Pamela K	RN	25Apr2008 17:42
BRADEN ASMNT				
BRADEN SCALE				
Sensory perception	4	Fulton, Pamela K	RN	25Apr2008 17:43
Skin moisture	3	Fulton, Pamela K	RN	25Apr2008 17:43
Activity level	4	Fulton, Pamela K	RN	25Apr2008 17:43
Mobility	4	Fulton, Pamela K	RN	25Apr2008 17:43
Nutrition status	1	Fulton, Pamela K	RN	25Apr2008 17:43
Friction and shear	3	Fulton, Pamela K	RN	25Apr2008 17:43
BRADEN SCALE TOTAL-	19	Fulton, Pamela K	RN	25Apr2008 17:43
NUTRITION SCREENING-A				
NUTRITION VS				
Height (cm)	175.26	Fulton, Pamela K	RN	25Apr2008 17:43
Weight (kg)	63.6	Fulton, Pamela K	RN	25Apr2008 17:44
BMI body mass index	20.70	Fulton, Pamela K	RN	25Apr2008 17:44

*** End of data ***

X519-P KUNKEL, Troy D MR#: 17330138 ACCT: 147322952
AGE: 25Y DOB: [redacted]1983 GENDER: M
Admitting: Unknown CC:
Attending: Unknown REASON FOR ADM:

ALLERGY/INTOLERANCES

Medication Allergies	Reaction
MEDS-NKA	

Intolerances
Food Intolerances
No Known Food Allergies
Contrast Media Intolerances
No Known Contrast Media Intolerance
Other Intolerances
latex

CATEGORY/FINDING	RESULT	CAREGIVER	TITLE
FORM: DISCHARGE_FLOWSHEET	**Date: 26Apr2008**	**Time: 12:49**	
DISCHARGE_CHECKLIST			
APPOINTMENT/REFERRAL			
Follow-up appts made/orders provided	Y	Pipe on head, Genevieve J	LPN
MEDICATION/OTH INFO			
Med reconciliation w/pre-hospital meds	Y	Pipe on head, Genevieve J	LPN
Hazardous medication info given	Y	Pipe on head, Genevieve J	LPN
Verbal advice to quit tobacco given	Yes	Pipe on head, Genevieve J	LPN
IMMUNIZATION/VACCINE			
Date of last Pneumococcal vaccine (yr)	2007	Pipe on head, Genevieve J	LPN
Pneumococcal vaccine decision	Current	Pipe on head, Genevieve J	LPN
Date of last Influenza vaccine (mo/yr)	2007	Pipe on head, Genevieve J	LPN
Influenza vaccine decision	Current	Pipe on head, Genevieve J	LPN
BELONGINGS-TX/DC			
Glasses/Contacts	With fam	Pipe on head, Genevieve J	LPN
DISCHARGE SUMMARY			
Discharge instructions given	Y	Pipe on head, Genevieve J	LPN
Verbalizes understanding	Patient	Pipe on head, Genevieve J	LPN
Pt condition at discharge	stable	Pipe on head, Genevieve J	LPN
Disch'd with home medication list	Y	Pipe on head, Genevieve J	LPN
Prescriptions called/faxed to pharmacy	Called	Pipe on head, Genevieve J	LPN
Discharged to	Home w/fam	Pipe on head, Genevieve J	LPN
Discharge mode	Ambulatory	Pipe on head, Genevieve J	LPN
FORM: ADULT ASSESSMENT FF	**Date: 26Apr2008**	**Time: 08:00**	
ADULT ASSESSMENT WNL			
Neurological assessment	WNL	Pipe on head, Genevieve J	LPN
Psychosocial assessment	WNL	Pipe on head, Genevieve J	LPN
EENT assessment	WNL	Pipe on head, Genevieve J	LPN
Cardiovascular assessment	WNL Except	Pipe on head, Genevieve J	LPN

SLT0171

1005B-016

X519-P KUNKEL, Troy D MR#: 17330138 ACCT: 147322952 I
AGE: 25Y DOB: [redacted]1983 GENDER: M
Admitting: PETERSON, PAUL D CC: possible meningitis
Attending: Unknown REASON FOR ADM: possible meningitis

CATEGORY/FINDING	RESULT	CAREGIVER	TITLE
ADULT ASSESSMENT WNL			
Respiratory assessment	WNL Except	Pipe on head, Genevieve J	LPN
Gastrointestinal assessment	WNL	Pipe on head, Genevieve J	LPN
Genitourinary assessment	WNL	Pipe on head, Genevieve J	LPN
Integumentary asssessment	WNL	Pipe on head, Genevieve J	LPN
Musculoskeletal assessment	WNL	Pipe on head, Genevieve J	LPN
FORM: ADULT ASSESSMENT FLOWSHEET	Date: 26Apr2008	Time: 08:00	
CARDIOVASCULAR-ASMT			
CARDIOVAS ASMT			
Heart sounds	Distant	Pipe on head, Genevieve J	LPN
DVT ASSESSMENT			
Homan's sign	Negative	Pipe on head, Genevieve J	LPN
RESPIRATORY-ASMT			
RESPIRATORY ASMT			
Coarse	Throughout	Pipe on head, Genevieve J	LPN
Expiratory wheezes	Throughout	Pipe on head, Genevieve J	LPN
Inspiratory wheezes	Throughout	Pipe on head, Genevieve J	LPN
Scattered			
Cough	Productive	Pipe on head, Genevieve J	LPN
Respiratory-other	No note	Pipe on head, Genevieve J	LPN
PULMONARY HYGIENE			
Cough and deep-breathe effort	Good	Pipe on head, Genevieve J	LPN
INTEGUMENTARY ASSESSMENT			
BRADEN SCALE			
Sensory perception	4	Pipe on head, Genevieve J	LPN
Skin moisture	4	Pipe on head, Genevieve J	LPN
Activity level	4	Pipe on head, Genevieve J	LPN
Mobility	4	Pipe on head, Genevieve J	LPN
Nutrition status	3	Pipe on head, Genevieve J	LPN
Friction and Shear	3	Pipe on head, Genevieve J	LPN
BRADEN SCALE TOTAL=	22	Pipe on head, Genevieve J	LPN
PREVENTIVE SKIN CARE			
Diabetes	Insulin	Pipe on head, Genevieve J	LPN
FALL RISK/SAFETY ASSESSMENT			
FALL RISK/SAFETY			
History of falling	0	Pipe on head, Genevieve J	LPN
Secondary diagnosis	0	Pipe on head, Genevieve J	LPN
Ambulatory aid	0	Pipe on head, Genevieve J	LPN
IV therapy/saline lock	20	Pipe on head, Genevieve J	LPN
Gait	0	Pipe on head, Genevieve J	LPN
Mental status	0	Pipe on head, Genevieve J	LPN
MORSE FALL SCALE SCORE	20	Pipe on head, Genevieve J	LPN

SLT0172

X519-P KUNKEL, Troy D MR#: 17330138 ACCT: 147322952 I
AGE: 25Y DOB: [redacted]1983 GENDER: M
Admitting: PETERSON, PAUL D CC: possible meningitis
Attending: Unknown REASON FOR ADM: possible meningitis

CATEGORY/FINDING	RESULT	CAREGIVER	TITLE
MEDS INC FALL RISK			
None identified	Y	Pipe on head, Genevieve J	LPN
RISK/UNIVRSL INTERVN			
Risk for falls	Low risk	Pipe on head, Genevieve J	LPN
Universal interventions	Y	Pipe on head, Genevieve J	LPN
Teach inc risk to fall unfam surrounding	Y	Pipe on head, Genevieve J	LPN
INDIVIDUALIZED INTV			
Individualized intervention other	call light	Pipe on head, Genevieve J	LPN

FORM: ADULT ASSESSMENT FF Date: 26Apr2008 Time: 04:00

ADULT ASSESSMENT WNL			
Neurological assessment	WNL	Ebert, Jackie M	
Psychosocial assessment	WNL	Ebert, Jackie M	
EENT assessment	WNL	Ebert, Jackie M	
Cardiovascular assessment	WNL	Ebert, Jackie M	
Respiratory assessment	WNL Except	Ebert, Jackie M	
Gastrointestinal assessment	WNL	Ebert, Jackie M	
Genitourinary assessment	WNL	Ebert, Jackie M	
Integumentary assessment	WNL	Ebert, Jackie M	
Musculoskeletal assessment	WNL	Ebert, Jackie M	
NURSES NOTES			
Nursing note	Note	Shilling, Rana J	RN
Co-signed student assessment, Rana Shilling RN			

FORM: RESPIRATORY FS Date: 26Apr2008 Time: 04:00

RESPIRATORY-ASMT			
RESPIRATORY ASMT			
Coarse	Throughout	Ebert, Jackie M	
Expiratory wheezes	Throughout	Ebert, Jackie M	
Inspiratory wheezes	Throughout	Ebert, Jackie M	
Scattered			
Cough	Productive	Ebert, Jackie M	
Respiratory-other	See note	Ebert, Jackie M	
Nasal swab for influenza obtained and sent to lab.			
OXYGENATION			
Oxygen device	None	Ebert, Jackie M	
PULMONARY HYGIENE			
Cough and deep breathe effort	Good	Ebert, Jackie M	

SLT0173

X519-D KUNKEL, Troy D MR#: 17300138 ACCT: 147322952 I
AGE: 25Y DOB: [redacted]1983 GENDER: M
Admitting: PETERSON, PAUL D CC: possible meningitis
Attending: Unknown REASON FOR ADM: possible meningitis

CATEGORY/FINDING	RESULT	CAREGIVER	TITLE
FORM: GU-REPRODUCTIVE FS	Date: 26Apr2008	Time: 04:00	
GU.ASSESSMENT			
Urine color	yellow	Ebert, Jackie M	
GU -other	See note	Ebert, Jackie M	
UA obtained and sent to lab.			
FORM: ADULT ASSESSMENT FF	Date: 26Apr2008	Time: 00:01	
ADULT ASSESSMENT WNL			
Neurological assessment	WNL	Shilling, Rana J	RN
Psychosocial assessment	WNL	Shilling, Rana J	RN
EENT assessment	WNL	Shilling, Rana J	RN
Cardiovascular assessment	WNL	Shilling, Rana J	RN
Respiratory assessment	WNL Except	Shilling, Rana J	RN
Gastrointestinal assessment	WNL	Shilling, Rana J	RN
Genitourinary assessment	WNL	Shilling, Rana J	RN
Integumentary assessment	WNL	Shilling, Rana J	RN
Musculoskeletal assessment	WNL	Shilling, Rana J	RN
NURSES NOTES			
Nursing note	Note	Shilling, Rana J	RN
Co-signed student assessment, Rana Shilling RN			
FORM: RESPIRATORY FS	Date: 26Apr2008	Time: 00:01	
RESPIRATORY-ASMT			
RESPIRATORY ASMT			
Coarse	Throughout	Ebert, Jackie M	
Expiratory wheezes	Throughout	Ebert, Jackie M	
Inspiratory wheezes	Throughout	Ebert, Jackie M	
Scattered			
Cough	Productive	Ebert, Jackie M	
PULMONARY HYGIENE			
Cough and deep breathe effort	Good	Ebert, Jackie M	
FORM: ADULT ASSESSMENT FF	Date: 25Apr2008	Time: 20:00	
ADULT ASSESSMENT WNL			
Neurological assessment	WNL	Shilling, Rana J	RN
Psychosocial assessment	WNL	Shilling, Rana J	RN
EENT assessment	WNL	Shilling, Rana J	RN
Cardiovascular assessment	WNL	Shilling, Rana J	RN

X519-P KUNKEL, Troy D MR#: 17330138 ACCT: 147322952 I
AGE: 25Y DOB: [redacted]1983 GENDER: M
Admitting: PETERSON, PAUL D CC: possible meningitis
Attending: Unknown REASON FOR ADM: possible meningitis

CATEGORY/FINDING	RESULT	CAREGIVER	TITLE
ADULT ASSESSMENT WNL			
Respiratory assessment	WNL Except	Shilling, Rana J	RN
Gastrointestinal assessment	WNL	Shilling, Rana J	RN
Genitourinary assessment	WNL	Shilling, Rana J	RN
Integumentary assessment	WNL	Shilling, Rana J	RN
Musculoskeletal assessment	WNL	Shilling, Rana J	RN
NURSES NOTES			
Nursing note	Note	Shilling, Rana J	RN
Co-signed student assessment, Rana Shilling RN			

FORM: RESPIRATORY FS Date: 25Apr2008 Time: 20:00

RESPIRATORY ASMT			
RESPIRATORY ASMT			
Coarse	Throughout	Ebert, Jackie M	
Expiratory wheezes	Throughout	Ebert, Jackie M	
Inspiratory wheezes	Throughout	Ebert, Jackie M	
Scattered			
Cough	Productive	Ebert, Jackie M	
PULMONARY HYGIENE			
Cough and deep-breathe effort	Good	Ebert, Jackie M	

FORM: SCREENING CATEGORIES -A Date: 25Apr2008 Time: 20:00

FALL RISK/SAFETY ASSESSMENT			
FALL RISK/SAFETY			
History of falling	0	Ebert, Jackie M	
Secondary diagnosis	0	Ebert, Jackie M	
Ambulatory aid	0	Ebert, Jackie M	
IV therapy/saline lock	20	Ebert, Jackie M	
Gait	0	Ebert, Jackie M	
Mental status	0	Ebert, Jackie M	
MORSE FALL SCALE SCORE	20	Ebert, Jackie M	
MEDS INC FALL RISK			
None identified	Y	Ebert, Jackie M	
RISK/UNIVRSL INTERVN			
Risk for falls	Low risk	Ebert, Jackie M	
Universal interventions	Y	Ebert, Jackie M	
Teach inc risk to fall-unfam surrounding	Y	Ebert, Jackie M	
INDIVIDUALIZED INTV			
Alarm in place	Bed	Ebert, Jackie M	
Individualized intervention other	call light	Ebert, Jackie M	
BRADEN ASMNT			

X519-P KUNKEL, Troy D MR#: 17330138 ACCT: 147322952 I
AGE: 25Y DOB: [redacted]1983 GENDER: M
Admitting: PETERSON, PAUL D CC: possible meningitis
Attending: Unknown REASON FOR ADM: possible meningitis

CATEGORY/FINDING	RESULT	CAREGIVER	TITLE
BRADEN SCALE			
Sensory perception	4	Ebert, Jackie M	
Skin moisture	3	Ebert, Jackie M	
Activity level	4	Ebert, Jackie M	
Mobility	4	Ebert, Jackie M	
Nutrition status	1	Ebert, Jackie M	
Friction and shear	3	Ebert, Jackie M	
BRADEN SCALE TOTAL=	19	Ebert, Jackie M	
PREVENTIVE SKIN CARE			
Diabetes	Insulin	Ebert, Jackie M	
FORM: ADULT ASSESSMENT FLOWSHEET	Date: 25Apr2008	Time: 19:05	
RESPIRATORY-ASMT			
RESPIRATORY ASMT			
Coarse	Throughout	Surber, Holli M	RN
Expiratory wheezes	Throughout	Surber, Holli M	RN
Inspiratory wheezes Scattered	Throughout	Surber, Holli M	RN
Cough	Productive	Surber, Holli M	RN
Sputum color	Grn/yellow	Surber, Holli M	RN
Sputum consistency	Thick	Surber, Holli M	RN
Sputum amount	Small	Surber, Holli M	RN
OXYGENATION			
Oxygen device	None	Surber, Holli M	RN
PULMONARY HYGIENE			
Cough and deep-breathe effort	Good	Surber, Holli M	RN
FORM: ADULT ASSESSMENT FF	Date: 25Apr2008	Time: 19:04	
ADULT ASSESSMENT WNL			
Neurological assessment	WNL	Surber, Holli M	RN
Psychosocial assessment	WNL	Surber, Holli M	RN
EENT assessment	WNL	Surber, Holli M	RN
Cardiovascular assessment	WNL	Surber, Holli M	RN
Respiratory assessment	WNL Except	Surber, Holli M	RN
Gastrointestinal assessment	WNL	Surber, Holli M	RN
Genitourinary assessment	WNL	Surber, Holli M	RN
Integumentary asssessment	WNL	Surber, Holli M	RN
Musculoskeletal assessment	WNL	Surber, Holli M	RN

SLT0176

1005B-021

X519-P KUNKEL, Troy D MR#: 17330138 ACCT: 147322952 I
AGE: 25Y DOB: [redacted]1983 GENDER: M
Admitting: PETERSON, PAUL D CC: possible meningitis
Attending: Unknown REASON FOR ADM: possible meningitis

CATEGORY/FINDING	RESULT	CAREGIVER	TITLE
FORM: SCREENING CATEGORIES -A	Date: 25Apr2008	Time: 17:41	
FALL RISK/SAFETY ASSESSMENT			
FALL RISK/SAFETY			
History of falling	0	Fulton, Pamela K	RN
Secondary diagnosis	0	Fulton, Pamela K	RN
Ambulatory aid	0	Fulton, Pamela K	RN
IV therapy/saline lock	20	Fulton, Pamela K	RN
Gait	0	Fulton, Pamela K	RN
Mental status	0	Fulton, Pamela K	RN
MORSE FALL SCALE SCORE	20	Fulton, Pamela K	RN
MEDS INC FALL RISK			
Antihypertensives	Y	Fulton, Pamela K	RN
None identified	Y	Fulton, Pamela K	RN
RISK/UNIVRSL INTERVN			
Risk for falls	Low risk	Fulton, Pamela K	RN
Universal interventions	Y	Fulton, Pamela K	RN
Teach inc risk to fall unfam surrounding	Y	Fulton, Pamela K	RN
INDIVIDUALIZED INTV			
Alarm in place	Bed	Fulton, Pamela K	RN
Individualized intervention other	See note Patient is encouraged to use the call light for assistance.	Fulton, Pamela K	RN
BRADEN ASMNT			
BRADEN SCALE			
Sensory perception	4	Fulton, Pamela K	RN
Skin moisture	3	Fulton, Pamela K	RN
Activity level	4	Fulton, Pamela K	RN
Mobility	4	Fulton, Pamela K	RN
Nutrition status	1	Fulton, Pamela K	RN
Friction and Shear	3	Fulton, Pamela K	RN
BRADEN SCALE TOTAL=	19	Fulton, Pamela K	RN
NUTRITION SCREENING-A			
NUTRITION VS			
Height (cm)	175.26	Fulton, Pamela K	RN
Weight (kg)	63.6	Fulton, Pamela K	RN
BMI-Body Mass Index	20.70	Fulton, Pamela K	RN
FORM: ADULT INITIAL HX	Date: 25Apr2008	Time: 17:30	
GENERAL ADMISSION DATA-AD			
ADMISSION DATA AD			
Orient to room/unit	Patient	Fulton, Pamela K	RN
Pt Bill of Rights/Responsibilities given	Patient	Fulton, Pamela K	RN

STF0177

1005B-022

X519-P KUNKEL, Troy D MR#: 17330138 ACCT: 147322952 I
AGE: 25Y DOB: [redacted]1983 GENDER: M
Admitting: PETERSON, PAUL D CC: possible meningitis
Attending: Unknown REASON FOR ADM: possible meningitis

CATEGORY/FINDING	RESULT	CAREGIVER	TITLE
ADMISSION DATA-AD			
Pain brochure given	Patient	Fulton, Pamela K	RN
Reason for admission	weakness	Fulton, Pamela K	RN
Admitted from	Dr office	Fulton, Pamela K	RN
Mode of arrival	Wheelchair	Fulton, Pamela K	RN
Info obtained from	Patient	Fulton, Pamela K	RN
ADVANCE DIRECTIVES			
Advance directive info provided by	Patient	Fulton, Pamela K	RN
Patient states	"Whatever it takes to revive Me"		
VALUABLES/DISPOSITION			
Glasses/Contacts	With fam	Fulton, Pamela K	RN
IMMUNIZATION/VACCINE HX			
IMMUNIZATIONS HX			
Date of last Pneumococcal vaccine (yr)	2007	Fulton, Pamela K	RN
Reason not to give Pneumococcal vaccine	Current	Fulton, Pamela K	RN
Pneumococcal vaccine decision	Current	Fulton, Pamela K	RN
Date of last Influenza vaccine (mo/yr)	2007	Fulton, Pamela K	RN
Reason not to give Influenza vaccine	Current	Fulton, Pamela K	RN
Influenza vaccine decision	Current	Fulton, Pamela K	RN
HM/VASC ACCESS/SURG/TRANS HX			
HOME MEDS-AD			
Home medications	Yes	Fulton, Pamela K	RN

CURRENT MEDICATIONS LIST
This is to be a list of all meds the patient has been taking: Prescription, Over the Counter, Vitamins, Herbs, etc

MEDICATION (include dose, frequency and last dose)

_Xanax 0.5mg every 6 hrs. 4/25/08
_Novolog Regular 10 units before meals. 4/25/08
_Propranolol 20mg twice daily. 4/25/08
_Lantus insulin 65 units in morning. 4/25/08
_

Hm med info prov by	Patient	Fulton, Pamela K	RN
Home pharmacy	greenville	Fulton, Pamela K	RN
Home meds disposition	Not w/pt	Fulton, Pamela K	RN
SURGICAL/PROCEDURAL HX			
Surgical / Procedural history	Yes	Fulton, Pamela K	RN

PAST SURGERIES/PROCEDURES

Surgery/Procedure Date
spleenectomy 9yrs old

TRANSFUSION HX			
Previous transfusions	No	Fulton, Pamela K	RN

SLT0178

1005B-023

X519-P KUNKEL, Troy D MR#: 17330138 ACCT: 14732952 I
AGE: 25Y DOB: [redacted]1983 GENDER: M
Admitting: PETERSON, PAUL D CC: possible meningitis
Attending: Unknown REASON FOR ADM: possible meningitis

CATEGORY/FINDING	RESULT	CAREGIVER	TITLE
MED HX-RESPIRATORY/CV/GI			
RESP HX			
Asthma	Y	Fulton, Pamela K	RN
Respiratory Hx-other	see note	Fulton, Pamela K	RN
	pt states he does have trouble breathing but denies use of inhalers etc. States mainly short of breath in AM & coughs up large amounts of sputum.		
CARDIOVASC HX			
Hypertension	Y	Fulton, Pamela K	RN
Arrhythmias (list)	Y	Fulton, Pamela K	RN
	pt states can detect his heart fluctuating in speed. States he has to sit down sometimes as his heart is beating so fast.		
GASTROINTESTIONAL HX			
Ulcers	Y	Fulton, Pamela K	RN
Gastrointestinal Hx-other	see note	Fulton, Pamela K	RN
	pt states it has been a long time since he has passed a regular formed stool. Currently he is passing runny or soft stool.		
MED HX-GU/REPR/NEURO/MS/ENT			
NEUROLOGICAL HX			
Headaches	Migraine	Fulton, Pamela K	RN
EENT HX			
Loose teeth	Y	Fulton, Pamela K	RN
EENT Hx-other	see note	Fulton, Pamela K	RN
	poor dental care		
MED HX-PSYCHOSOCIAL/MISC			
MISCELLANEOUS MEDICAL HX			
Diabetes	Insulin	Fulton, Pamela K	RN
Thyroid disorder	Y	Fulton, Pamela K	RN
	graves disease		
MEDICAL HISTORY.			
Personal Physician	Peterson	Fulton, Pamela K	RN
SUBSTANCE USAGE			
TOBACCO USAGE			
Tobacco use/exposure history	W/I 12 mo	Fulton, Pamela K	RN
	states quit last Sunday 12-2-7		
Tobacco type used	cigarettes	Fulton, Pamela K	RN
Tobacco amount/day	1pk /day	Fulton, Pamela K	RN
# years tobacco used	13	Fulton, Pamela K	RN
Verbal advice to quit tobacco given	Yes	Fulton, Pamela K	RN
Quit tobacco info given	Stay quit	Fulton, Pamela K	RN
Doesn't want more info to quit tobacco	Y	Fulton, Pamela K	RN
Would like more info to quit tobacco	Y	Fulton, Pamela K	RN
CAFFEINE USAGE			

SIT0179

1005B-024

X519-P KUNKEL, Troy D MR#: 17330138 ACCT: 147322952 I
AGE: 25Y DOB: [redacted]1983 GENDER: M
Admitting: PETERSON, PAUL D CC: possible meningitis
Attending: Unknown REASON FOR ADM: possible meningitis

CATEGORY/FINDING	RESULT	CAREGIVER	TITLE
CAFFEINE USAGE			
Caffeine intake/day	Min amt	Fulton, Pamela K	RN
ALCOHOL/OTHER SUBSTANCES			
Alcohol type	none	Fulton, Pamela K	RN
quit 6-7 years			
Street drug use	Y	Fulton, Pamela K	RN
Not since a teenager.			
LEARNING NEEDS ASMT			
PT-CAREGIVER LEARNING NEEDS			
Receptive to learning	Yes	Fulton, Pamela K	RN
Patient preferred learning style	Reading	Fulton, Pamela K	RN
Patient-How happy are you w/your reading	Read well	Fulton, Pamela K	RN
LEARNING BARRIERS			
No learning barriers identified	Y	Fulton, Pamela K	RN
SOCIAL FACTORS/DC PLANNING			
ABUSE SCREENING			
Been hurt or made to feel afraid	No	Fulton, Pamela K	RN
Feel exploited/taken advantage of	No	Fulton, Pamela K	RN
Feel neglected	No	Fulton, Pamela K	RN
Feel threatened	No	Fulton, Pamela K	RN
CULTURAL-SPIRITUAL			
Spiritual concerns	None	Fulton, Pamela K	RN
Cultural tradition needs during stay	None	Fulton, Pamela K	RN
DISCHARGE PLANNING			
Residence before hospitalization	Hm w/o help	Fulton, Pamela K	RN
Discharge plan A	Home w/fam	Fulton, Pamela K	RN
CONTACT INFORMATION			
1st Contact Person	megan	Fulton, Pamela K	RN
712-277-2400 home	cell 712-574-4623		
HOME MEDICAL EQUIP			
Other medical supplies/equipment	none	Fulton, Pamela K	RN
SCREENING CATEGORIES FF			
LATEX SCREEN FF			
No latex allergy	Y	Fulton, Pamela K	RN

*** End of data ***

***** The following footnotes are explanations of 'WITHIN NORMAL LIMITS' ***** Page
Adult Assessment
Neurological
WNL - Alert and responsive. Oriented to person/place/time. Speech clear. Obeys verbal command, move all extremities equally and with purpose. No facial droop present, denies numbness or tingling. Pupils equal/reactive to light. (On adm assess only)

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